adoption from the budget holders. However, if discounts approach 30%, physicians are likely to have less influence. **CONCLUSIONS:** Generally, budget holders and clinicians have differing views on the utility and placement of biosimilars in the clinical pathway. The uptake of which will ultimately depend on geographies, discounts offered and clinician experience. Biosimilars are not going away, however, there are strategies that the originator company can utilize and leverage to delay uptake and maintain strong market share.

PCN65

THE CLINICAL AND ECONOMIC BURDEN OF POST-THORACOTOMY PAIN SYNDROME (PTPS) AFTER LUNG RESECTION SURGERY: A RETROSPECTIVE ANALYSIS OF REAL-WORLD DATA

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OBJECTIVES: Post-thoracotomy pain syndrome (PTPS) is widely reported as one of the primary comorbidities following lung resection surgery. The objective of this retrospective study was to quantify the clinical and economic burden of post-thoracotomy pain syndrome (PTPS) following lung resection surgery in the United States using a large real-world database. **METHODS:** This study utilized claims data from the Truven MarketScan databases. Adult patients undergoing a lobectomy or a segmentectomy as the primary surgical procedure were categorized by the surgical approach (video-assisted thoracoscopic surgery (VATS) versus open) and primary diagnosis (lung cancer vs. non-lung cancer). The PTPS cohort was identified based on a diagnosis of non-neurogenic and neurogenic pain lasting more than two months post-operatively. Data were collected for: patient demographics, index hospital costs and post-discharge costs. Mean, standard deviation, median values are reported for observed differences between the groups. **RESULTS:** A total of 5,502 patients (4,898 lung cancer and 604 non-lung cancer) met the study criteria. The incidence of PTPS was 5% (n=261) in the cancer group and 7% (n=42) in the non-cancer group. PTPS was more common following open procedures vs VATS (6.1% vs. 4.6%). The one year observed post-discharge costs were consistently higher in the PTPS cohort vs. the non-PTPS cohort for both cancer and non-cancer patients with a greater difference of mean values in the cancer group (cancer: $36,872±$23,035 vs. $31,728±$15,176; non-cancer: $16,497±$9,822 vs. $16,040±$5,988). PTPS patients diagnosed in the first two months post-operatively cost more to manage than the corresponding non-PTPS cohort (cancer: $39,159±$40,030 vs. $32,302±$50,336; non-cancer: $16,584±$14,233 vs. $11,005±$19,371). **CONCLUSIONS:** Real world data shows a lower rate of PTPS in the US when compared to data published in the peer-reviewed literature, suggesting an under-reporting of PTPS in claims databases. PTPS is more common following open procedures and the post-discharge cost of managing PTPS patients is higher than non-PTPS patients.

PCN66

THE CLINICAL AND ECONOMIC BURDEN OF SIGNIFICANT BLEEDING DURING LUNG RESECTION SURGERY: A RETROSPECTIVE MATCHED COHORT ANALYSIS OF REAL-WORLD DATA

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OBJECTIVES: There is increasing clinical evidence to support the adoption of video assisted thoracoscopic surgery (VATS) for lung resection procedures. While the frequency of significant intraoperative bleeding requiring follow-up interventions is generally low, there is a lack of real-world data quantifying its incidence and cost of management. The objective of this retrospective study was to quantify the clinical and economic burden of significant bleeding in lung resection surgery in the United States. **METHODS:** This study utilized 2009-2012 data from the Premier Perspective DatabaseTM. Adult patients with primary pulmonary lobectomy or segmentectomy procedures were categorized by the surgical approach (VATS versus open) and primary diagnosis (lung cancer (primary or metastatic) vs. non-lung cancer). Data were collected for patient demographics, length of stay, cost and amount of blood product utilized. Patients requiring ≥3 units of blood products were categorized as the "significant bleeding" cohort. Those requiring <3 units were the "non-significant bleeding" cohort and those not requiring any blood products were the "no bleeding" cohort. A matched cohort analysis was performed between the "significant bleeding" and the "non-bleeding cohort" using the following matching variables: hospital identifier, lung cancer diagnosis, procedure type and gender. **RESULTS:** A total of 29,737 patients (20,370 in the lung cancer group and 9,367 in the non-lung cancer group) met the selection criteria. The matched cohort analysis showed a higher cost for the "significant bleeding" cohort vs. the "non-bleeding" cohort ($32,140 vs. $19,037). The matched analysis for each APR-DRG Severity score showed that the significant bleeding cohort cost more for the hospital than the non-bleeding cohort. **CONCLUSIONS:** Significant chest bleeding during lung resection surgery is a rare complication in the US, occurring with a frequency of 0.63%. However, patients with significant intraoperative bleeding could cost an average of $13,103 more for the hospital to manage and have a longer length of stay.

PCN67

EVALUATING THE COST OF TREATING BLADDER CANCER WITH AND WITHOUT METASTASES

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OBJECTIVES: Recent systematic literature reviews of bladder cancer (BC) indicated that more economic research on management strategies, particularly in the metastatic setting, is needed. This study evaluated the cost of care among patients diagnosed and treated for BC with and without metastases. **METHODS:** Retrospective data from 2 large integrated claims databases spanning July 2008 to December 2010 were used to identify adult patients with a diagnosis of malignant neoplasm of the bladder (ICD-9 188.0–188.9; ICD-10 C67.0–67.9). Patients were included if they (1) had continuous eligibility for 6 months prior to at least 6 months following their index diagnosis, (2) had no diagnosis of any other cancer in the pre-period, and (3) received no chemotherapy in the pre-period. Patients were stratified into 2 cohorts based on the presence of metastatic disease within 180 days of diagnosis: non-metastatic (NM) and metastatic (M). Resource use and all-cause costs (2013 USD) were evaluated after cancer diagnosis. **RESULTS:** There were 10,250 (9,268 NM, 982 M) and 22,965 (20,786 NM, 2,179 M) patients in each of the databases meeting all inclusion criteria, respectively. Mean follow-up was 35.1 months and 38.6 months in the 2 datasets. Total costs 6 months prior to index ranged from $6,497–$6,852 (NM) and $6,766–$7,831 (M) and increased to $13,127–$13,559 (NM) and $40,695–$45,817 (M) in the 6-month post-index period. The majority of costs in the 6-month post-index period were attributable to medical services: NM, 88.7%–91.8%; M, 94.8%–96.5%. Inpatient and emergency department costs accounted for 38.2%–40.8% (NM) and 50.4%–52.5% (M) of total medical costs. **CONCLUSIONS:** Healthcare costs are highest among BC patients with metastatic disease, totaling as much as $45,817 in the 6-month period after diagnosis. Approximately 50% of costs are related to inpatient and emergency department services.

PCN68

COST OF CARE FOR GASTRIC CANCER IN PATIENTS WITH AND WITHOUT METASTASES

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OBJECTIVES: Due to the paucity of data with respect to real-world costs of care among individuals with gastric cancer (GaCa), the objective of this analysis is to evaluate the cost of care among individuals diagnosed with GaCa in 2 large retrospective databases. **METHODS:** Two large integrated claims databases spanning July 2008 to September 2012 were used to identify patients ≥18 years old diagnosed and treated for GaCa. Patients were required to be chemotherapy-naïve, continuously enrolled for ≥6 months pre- and post-diagnosis, and have no other cancer diagnosis at baseline. Eligible patients were stratified into cohorts based on the presence and timing of metastasis (M) diagnosis: no metastasis (NM), ≤120 days (M1), and ≥121 days (M2). All costs were adjusted to 2013 dollars. **RESULTS:** There were 5,609 (3,486 NM, 1,469 M1, 654 M2) and 3,203 (2,004 NM, 875 M1, 324 M2) patients in each of the databases, with 189 and 23, respectively, without cost data. Mean follow-up was 24 months in one dataset and 25 months in the other. Total average monthly costs at baseline were: NM $770–$847; M1 $662–$773; and M2 $634–$1,020. Total average monthly costs during follow-up were: NM $1,631–$2,004; M1 $9,813–$9,945; and M2 $6,598–$8,465. Medical costs represented 86%, 94%, and 93% of monthly costs for NM, M1, and M2 patients, respectively. Overall, 33% of patients received chemotherapy during follow-up and mean monthly chemotherapy-related costs were $966–$1,109, $2,502–$3,079, and $1,480–$1,521 for NM, M1, and M2, respectively. **CONCLUSIONS:** The results demonstrate the high burden to treat this population, with the highest costs in the group with metastases at diagnosis (M1) and medical-related costs as a major driver of overall treatment costs.

PCN69

COST OF TREATMENT OF RADIOPHARMACEUTICAL AND CHEMOTHERAPY FOR THE TREATMENT OF CASTRATION-RESISTANT PROSTATE CANCER WITH BONE METASTASES IN HOSPITAL SETTING

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OBJECTIVES: A substantial proportion of prostate cancer care is expected to be completed in the outpatient hospital setting; however, there is limited information on the actual cost of care in this setting. The objective of this analysis was to evaluate the total annual costs of treatments for castration-resistant prostate cancer (CRPC) with bone metastases for the following agents: cabazitaxel, docetaxel, radium 223, and sipuleucel-T. **METHODS:** An economic model was developed from the hospital outpatient perspective with a 1-year time horizon. The expected cost of each treatment from the outpatient practice perspective was based on reported per-visit treatment costs, professional/administration costs, laboratory/monitoring costs, and allocated overhead costs. The total treatment cost per visit was multiplied by the annual number of expected treatment cycles to calculate annual treatment costs. Hospital-specific adverse event (AE) costs were applied to published grade 3 and 4 AE rates for each comparator and added to the total cost per treatment. **RESULTS:** The total annual cost of therapy was lowest for docetaxel ($72,051), followed by radium 223 ($92,489), cabazitaxel ($93,742), and sipuleucel-T ($101,499). The treatment cost per visit was highest for sipuleucel-T ($30,936), followed by radium 223 ($12,362), cabazitaxel ($11,564), and docetaxel ($3,396). AE cost were $765 for sipuleucel-T, $5,123 for radium 223, $8,074 for cabazitaxel, and $11,223 for docetaxel. **CONCLUSIONS:** Total annual costs for CRPC treatments ranged from $72,000 to $101,500 per patient. Docetaxel had the lowest total annual costs, followed by radium 223, cabazitaxel, then sipuleucel-T, while sipuleucel-T had the lowest AE costs followed by radium 223, cabazitaxel, and docetaxel.

PCN70

COST – EFFICACY STUDY FOR IPILIMUMAB IN THE CHILEAN MARKET

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OBJECTIVES: To establish the cost per month of mean overall survival improvement, in Chilean patients treated with ipilimumab, from a third payer perspec-